

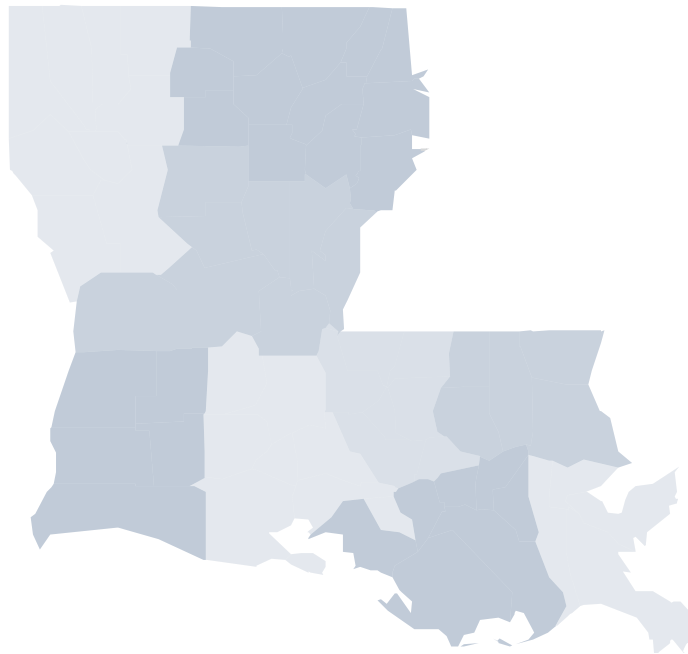


UNDERSTANDING THE IMPACT OF A MEDICAID EXPANSION IN LOUISIANA

Considerations, Assumptions and Uncertainties

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WHITE PAPER



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Introduction:

On March 26 - 28, 2012 the United States Supreme Court heard arguments in a case (NFIB v. Sebelius and Florida v. HHS) challenging certain provisions of the Patient Protection and Affordable Care Act (PPACA). In its majority opinion, the Court ruled that Congress had exceeded its power by threatening to withhold existing federal Medicaid funding to states that did not comply with the requirements to expand their programs in compliance with PPACA. With this ruling, each Governor and legislature is faced with a decision regarding the expansion of the state's Medicaid program. While Louisiana has elected not to expand its Medicaid program, this report outlines previous analyses of the impact of an expansion in Louisiana, the considerations and assumptions included, updates to these assumptions and continuing uncertainties.

It is important to reiterate that Louisiana does not believe that simply enrolling an individual in Medicaid guarantees their ability to access high quality health care services. State policy makers cannot afford to ignore the fact that expanding an inefficient 1960s-era entitlement program limits choice and fails to fully integrate its recipients into the broader health care system. While Louisiana has modernized its program to the extent allowed under federal regulations over the last year through the introduction of Bayou Health, there still exist many limitations to state-led innovation that can only be accomplished through a complex and cumbersome waiver process. Without fundamental reform, expanding Medicaid to millions of additional Americans is not the victory many envision. Louisiana continues to seek market-driven solutions to strengthen its existing Medicaid program, regardless of any past or future considerations of expanding the program.

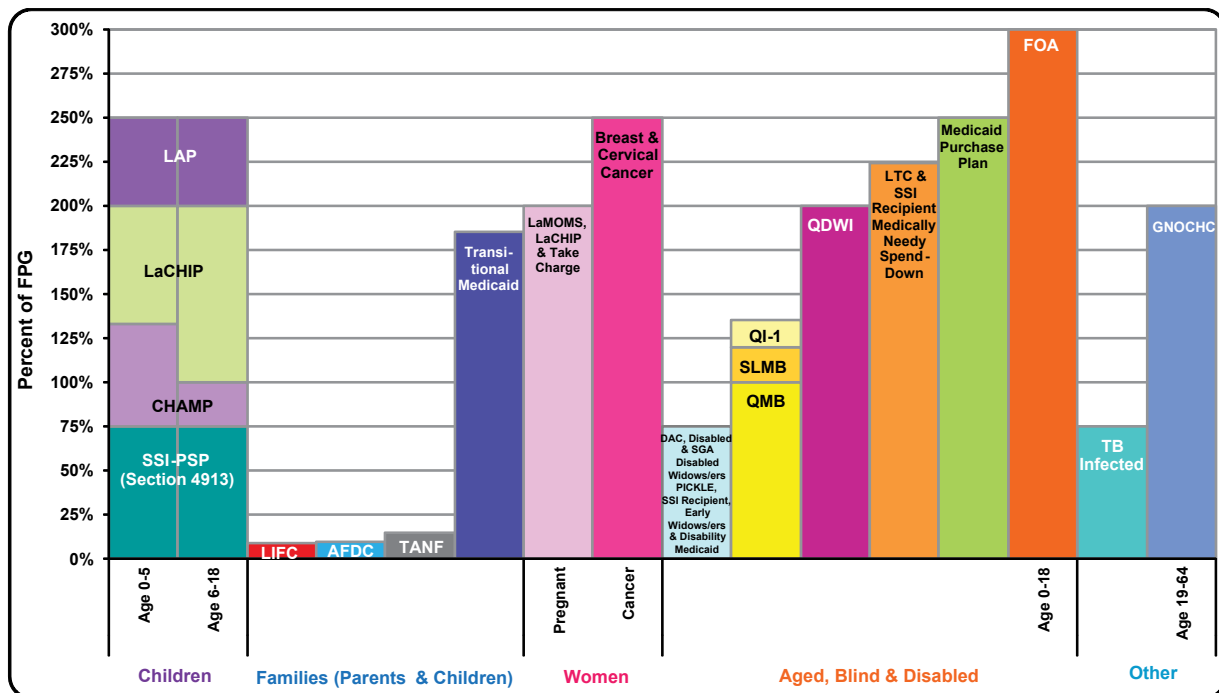
Eligibility in Louisiana Medicaid Today

Louisiana Medicaid has certain eligibility criteria for different populations of Louisiana residents. This includes all individuals who receive Supplemental Security Income (SSI) and families who receive assistance through Louisiana's Temporary Aide to Needy Families (TANF) program. Individuals not automatically eligible must fit within certain income ranges within one of four major categories:

- ▶ Aged – individuals age 65 or older
- ▶ Blind – individuals who have corrected vision not exceeding 20/200
- ▶ Families with Children – individuals who are pregnant or a caregiver of a child under age 18, a child under age 19,
- ▶ Disabled – individuals who meet Social Security

Administration (SSA) disability criteria and have a terminal condition or condition that prevents employment for a period of 12 consecutive months, or a woman in need of treatment for breast or cervical cancer

The individual or family meets all of the eligibility requirements of one or more Medicaid programs, which are summarized in the below chart. In general, Louisiana Medicaid offers generous eligibility for children and pregnant women, and moderate eligibility for people with disabilities. Louisiana generally offers coverage up to about 11 percent of the federal poverty level (FPL) for parents and caretakers, and does not offer coverage for childless adults without a disability or some other qualifying event.



Louisiana Medicaid Categories of Eligibility

The PPACA Expansion

The law includes an optional Medicaid expansion to all eligible individuals with household incomes up to 133 percent FPL based on Modified Adjusted Gross Income (line 37 of the IRS 1040) without asset tests and with a 5 percent income disregard. The federal enhanced matching rate schedule for newly eligible individuals:

- ▶ 100 percent FMAP for benefits for newly eligible individuals in calendar quarters 2014, 2015, and 2016,
- ▶ 95 percent FMAP for calendar quarters 2017,
- ▶ 94 percent FMAP for calendar quarters 2018,
- ▶ 93 percent FMAP for calendar quarters 2019, and
- ▶ 90 percent FMAP for calendar quarters 2020 and future years.

There are three primary populations to consider in the context of determining an impact of PPACA and the Medicaid expansion:

1. Currently eligible individuals who are not yet enrolled (commonly referred to as the “woodwork” population)

2. Newly eligible individuals who were previously uninsured
3. Newly eligible individuals who previously carried some form of private insurance (commonly referred to as “crowd-out” population)

Louisiana’s Uninsured

As noted in recent research publications, significant variations exist in the estimation of the number of uninsured Louisiana residents. National surveys routinely peg Louisiana’s uninsured population at 800 to 900 thousand individuals, while a state survey estimates the number of state residents lacking insurance to be closer to 650,000. It is important to remember that significant differences also exist in the sampling size in the methodologies of these survey instruments. Some surveys ask respondents about their insured status at a point in time, while others ask for their status over a certain time period, like the previous calendar year. In addition, certain surveys ask specifically about Medicaid coverage while others do not, leading them to undercount Medicaid enrollees. There also exist significant differences in the sampling size of these

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surveys. Often-cited estimates by the Urban Institute and Kaiser Commission on Medicaid are generally based on the Census Bureau's March 2011 and 2012 Annual Social and Economic Supplement (ASEC) to the US Census Bureau's Current Population Survey (CPS), a survey of around 78,000 households. Other estimates published by Kaiser are from the American Community Survey (ACS), an ongoing survey of about two million households annually. These two surveys produce results differing by more than 100,000 individuals. Assuming Louisiana had an equal share of surveys as our state population's share of the national population (~1.5 percent), the CPS estimate would be based on a survey of approximately 1,170 households in Louisiana, or .07 percent of our 1,675,097 households total.

State policymakers have typically relied on the Louisiana Health Insurance Survey (LHIS), a biannual survey conducted by the LSU Public Policy Research Lab and sponsored by the Louisiana Department of Health and Hospitals. Each round of the LHIS has been based on over 10,000 Louisiana households and 27,000 Louisiana residents, making the results likely to be more representative of the reality in Louisiana. According to the 2011 Louisiana Health Insurance Survey, there were approximately 653,000 uninsured individuals in Louisiana¹. The vast majority (633,000) of these are adults. In fact, from 2003-2011, the percent of uninsured children declined from 11.1 percent to 3.5 percent, resulting in over 100,000 fewer uninsured children in Louisiana. However, the number of uninsured adults has crept slowly upward by 93,452 since the last survey in 2009. According to the survey, this reflects the combined effect of a growing population and an increase in the uninsured rate among adults under age 65—from 20.1 percent in 2009 to 22.7 percent in 2011. For individuals below 138 percent of FPL, the rate of uninsurance was 38.5 percent for adults under age 65 and 3.2 percent for children in 2011.

LA's Uninsured Population: A Report from the 2011 LA Health Insurance Survey, January 2012

FPL Category	% Population Uninsured in this Income Category	Number of Uninsured Individuals
0% to 13% FPL	32.1%	101,618
13% to 100% FPL	47.3%	112,279
100% to 138% FPL	38.3%	77,291
138% to 150% FPL	40.5%	31,695
150% to 200% FPL	34.7%	93,039
200% to 250% FPL	23.5%	54,780
250% to 300% FPL	20.2%	41,814
300% to 400% FPL	14.4%	52,721

Distribution of Total Population by Federal Poverty Level, states (2010-2011), U.S. (2011) View 50-State Comparison²

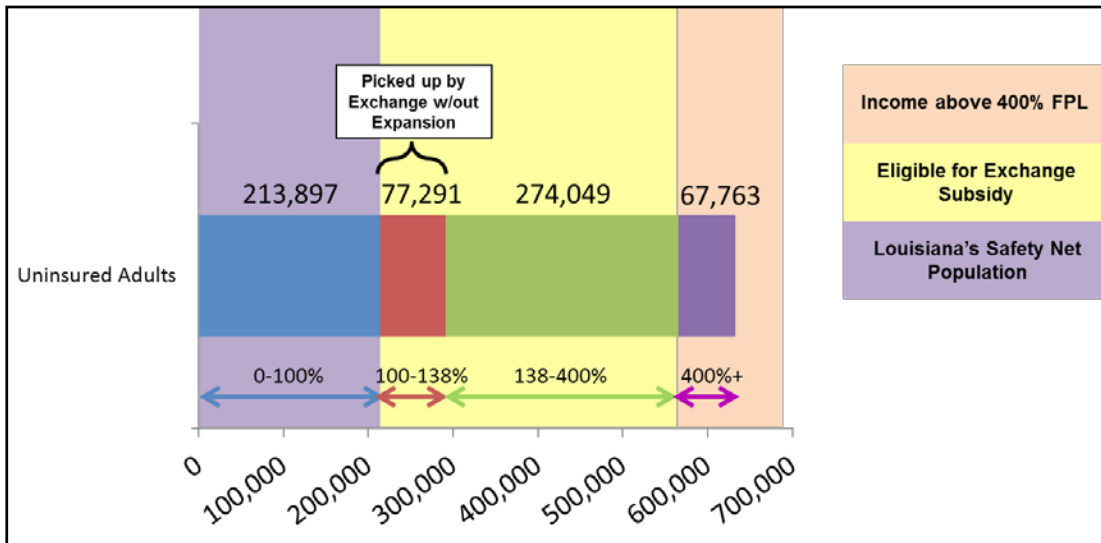
	LA #	LA %
Under 100%	1,202,000	27%
100-138%	376,700	8%
139-250%	790,100	18%
251-399%	842,200	19%
400%+	1,244,300	28%
Total	4,455,200	100%

As policymakers continue to explore the considerations of a Medicaid expansion, it is important to narrow the population whose needs would continue to be unaddressed. Ultimately, because of the availability of advanced premium tax credits through the Federally-Facilitated Exchange, only 213,897 of the currently uninsured adults (about 34 percent) have incomes beneath the federal poverty level and would likely remain part of Louisiana's safety-net population without an expansion of Medicaid.

To be more specific, of the 633,000 uninsured adults estimated to reside in Louisiana:

- ▶ About 68,000 have incomes above 400 percent FPL (\$94,200 for a family of four)
- ▶ About 350,000 will be eligible for subsidy on the Exchange (including approximately 78,000 individuals who would qualify for subsidies through the Exchange, who would otherwise have qualified for Medicaid through Expansion)
- ▶ About 214,000 would remain as part of Louisiana's safety-net population

Louisiana's Uninsured by Federal



Considerations

Developing a comprehensive estimate of the impact of the PPACA on state budgets and programs is complicated by a number of unknowns and important considerations. This document will attempt to catalogue these issues to better inform the public discourse regarding the impact of a Medicaid expansion in Louisiana.

Participation (or 'Take-Up') Rates

Participation, or 'Take-Up', rates measure those eligible individuals in a state's population that actually enroll in Medicaid. It is important to remember that an expansion of Medicaid eligibility does not directly correlate to an expansion in enrollment. Eligible individuals will have to take some proactive step to enroll in the program. While there is no agreed upon standard for the expectation of participation rates in the Medicaid expansion, there are several elements that are anticipated to influence the rates, including:

1. Simplification of the eligibility process,
2. General requirement for all Americans to carry health coverage,

3. The creation of Health Insurance Exchanges, and
4. Marketing efforts surrounding these coverage changes.

It is important to consider the disparate populations that will enroll in Medicaid as part of or in correlation to the Medicaid expansion, and the different characteristics that may affect their participation rate.

1. **Newly Eligible but Previously Uninsured:** This population represents the group targeted by the Medicaid coverage provisions of the PPACA. Residents who fall into this category are likely to be adults between 19 and 65 who currently receive health care through the LSU system.
2. **Newly Eligible but Previously Privately Insured (Crowd-out):** It is anticipated that a significant number of individuals with private coverage will enroll in Medicaid due to the richer benefit offering and the fact that Medicaid is almost completely free with the exception of minimal cost-sharing. Individuals who purchase coverage on the individual market are anticipated to be more likely to drop that coverage than those

with employer-sponsored insurance. However, there remains a great deal of uncertainty on the impact of PPACA on employers of varying sizes over time.

3. Previously Eligible, but not Enrolled

(Woodwork): This effect is likely to occur, at least in large part, regardless of the State's decision to expand the Medicaid program.

Introduction of Bayou Health

The majority of Louisiana's 1.2 million Medicaid and LaCHIP recipients now have their care coordinated through a Health Plan network. Of the nearly 900,000 recipients who are part of Bayou Health, nearly 40 percent proactively chose a Health Plan for their families. New enrollees coming onto the program are making a proactive choice two-thirds of the time, marking an unprecedented level of consumer engagement in Louisiana's Medicaid program.

Bayou Health is the first fundamental transformation of Louisiana's Medicaid program since it was created in the late 1960s. More importantly, it was carefully designed to ensure better, more coordinated care for those who depend on us. The program's focus is on improved access to quality health care and better health outcomes for recipients. Under Bayou Health, DHH contracted with five Health Plans - Amerigroup RealSolutions, Community Health Solutions, LaCare, Louisiana Healthcare Connections and UnitedHealthcare Community Plan -- that are responsible for coordinating health care for recipients and working with them to address issues and empower them to take a more active role in their health.

Bayou Health is estimated to save Louisiana \$135.9 million this fiscal year. The program provides greater spending predictability than traditional fee-for-service Medicaid, and helps to better manage state risk.

Administrative Costs

Nationally, administrative costs in state Medicaid programs account for approximately 5.5 percent of benefit costs, with federal match set uniformly at 50/50 for most functions (some limited functions are financed by the federal government at 75 percent).

Overall administrative costs are financed by the federal government at 55 percent, thus states incur administrative costs at approximately 2.48 percent of benefit costs.

While the enhanced matching rate table covers medical expenses for the newly eligible population, administrative costs will continue to be matched according to the current match rates for those costs.

Change in FMAP

Federal Medical Assistance Percentages (FMAP) are the percentage rates used to determine the federal matching funds rate allocated annually to allowable Medicaid expenses in the varying states. Congressional action in July reduced Louisiana's Medicaid funding match rate to the lowest it has been in 25 years, dealing a nearly \$900 million total reduction to the department's SFY13 budget. While enhanced federal match is available for the newly eligible population, any cost estimates related to individuals who enroll as a result of the "woodwork" effect must take this lower FMAP rate into account.

Limited Benefit Populations

Expanding Medicaid offers certain opportunities to leverage enhanced federal matching dollars for limited benefit populations currently being cared for at lower match rate. These populations include the breast and cervical cancer program, medically needy spend down, disability Medicaid, and children aging out of foster care.

Realigning Medicaid Eligibility Programs

Beginning in 2014, PPACA will provide subsidized health insurance options for some adults who are currently eligible for Medicaid coverage in Louisiana. The Governor's FY 2014 executive budget proposes that Medicaid will synchronize its eligibility standards with these new, heavily subsidized health insurance options. Individuals will continue to have access to comprehensive, affordable health coverage that meets federal essential health benefits standards and caps individual out-of-pocket costs.

These changes, effective Jan. 1, 2014, include:

- ▶ Lowering the threshold for Medicaid coverage for pregnant women to those with incomes below 133 percent of FPL (those making less than \$30,000 per year for a family of four, in which the unborn child is counted toward family size). Women above this income range will be eligible to obtain affordable insurance through the federal health care exchange that will begin in January 2014. Enrollment begins on Oct. 1, 2013.
- ▶ Lowering the threshold of the Medicaid Purchase Plan/Ticket to Work eligibility category to those with incomes below 100 percent of FPL. This program provides Medicaid coverage for working people with disabilities. Those individuals with incomes above 100% Federal Poverty Level will be able to get affordable insurance through the federal exchange beginning in January 2014 with no exclusions for pre-existing conditions. Additionally, those who work for employers who have more than 50 employees will have health insurance offered to them.
- ▶ Changes in the Disability Medicaid eligibility category for individuals with disabilities who have incomes below 75 percent of FPL. In the current program, established after Hurricane Katrina, DHH contracts with local physicians to determine whether a qualifying disability exists rather than wait for a federal determination of Supplemental Security Income (SSI) eligibility. Medicaid will revert back to the protocol used prior to 2005, in which staff refer income-eligible individuals to the Social Security Administration to apply, and upon certification for SSI, they will be automatically eligible for Medicaid, retroactive to their date of SSI application (and up to three months prior).

These changes will generate more than \$24 million in SGF savings in FY 2014, which is already accounted for in the proposed budget.

Payments for the Uninsured (The Future of DSH Funding)

Louisiana has relied on the federal Disproportional Share Hospital (DSH) program to fund its public hospital safety net system for care for the uninsured

as well as the largely publicly run mental health system in Louisiana, and these dollars are generally required to be spent in inpatient settings. PPACA directs HHS to reduce aggregate Medicaid DSH allotments by \$.5 billion in 2014, \$.6 billion in 2015, \$.6 billion in 2016, \$1.8 billion in 2017, \$5 billion in 2018, \$5.6 billion in 2019, and \$4 billion in 2020; and, to carry out the reductions using a methodology that ties the reductions to state's rate of uninsured and that imposes a smaller percentage reduction on low DSH states.

Any combination of mandates to have health care coverage, Medicaid expansion to 133 percent FPL, and tax credits to purchase coverage through state exchanges for individuals with income below 400 percent FPL will not result in universal coverage. Due to exemptions and exclusions in the law, states will continue to have an uninsured population to whom essential health care services must be provided. It is estimated there will be 29 million uninsured in 2019, including undocumented immigrants, those between coverage for less than three months, those living in states that choose not to expand Medicaid, those who have religious objections, and those who choose not to have insurance and pay the penalties instead, such as young healthy people. It is unclear how states will pay for the uncompensated costs of health care services for the uninsured as DSH allotments are reduced, but it is clear that the need for uncompensated care will not diminish entirely.

Provider Reimbursement

The health care system as a whole is financed by a mix of public and private payer sources. Public programs, such as Medicare and Medicaid, often compensate health care providers below the cost of service while private insurers compensate at or above cost. In effect, private health insurance payments underwrite the cost of uncompensated care resulting from public program payments.

One of the little noted provisions of PPACA is the change in the definition of "medical assistance" in 42 USC 1396d. Under prior wording, it was well established that a State Medicaid agency was simply a payor of services. The law previously said that the State was solely responsible for the "payment of part

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or all of the cost of the following care and services.” The new wording established by PPACA extends the burden on States to “payment of part or all of the following care and services or the care and services themselves, or both.” This change in law opens the door to litigation based on the broader wording. It is likely to be argued in the near future that a State Medicaid agency is responsible not only for the payment of rates but for the actual service provision and possibly even the management of service delivery. In effect, this could result in jurisprudence that requires states to increase Medicaid reimbursement rates to a level that ensures sufficient provider participation and access to services. It is impossible to predict an exact cost impact this could have on states in the future, but it is an important consideration when discussing the liabilities associated with accepting a broad expansion of the Medicaid program.

Utilization Increases

Service utilization after an expansion of Medicaid would be likely to increase for multiple reasons. Pent up demand for health care will be met by increased Medicaid participation by physicians due to higher payment rates for primary care and (potentially) specialty services. Individuals currently served by the state hospital system, where utilization is limited by the availability of staff physicians and State funds appropriated for hospital services, will be served by private providers with a lower level of utilization constraints.

Behavioral Health Services

Many uninsured Louisianians currently utilize state and locally supported behavioral health services. In many cases, these services are funded purely with state and local resources. By gaining Medicaid coverage, there could be a decline in demand for these safety-net services and federal funding would become available. The exact amount is uncertain, and would vary on the degree that mental health and addictive disorder services are included in the benefits package for newly eligible individuals. In January, CMS released guidance to States on mental

health parity requirements applicable to Medicaid⁴. In general, PPACA extended the protections of the Mental Health Parity and Addiction Equity Act (MHPAEA) to Medicaid benchmark and benchmark-equivalent plans (now known as Alternative Benefit Plans).

Prisoner Care

Codified in Section 1905(a)(A) of the Social Security Act, the requirements for federal financial participation for incarcerated individuals eligible for Medicaid were clarified in a 1997 CMS letter to associate regional administrators. In general, states can use Medicaid to reimburse for off-grounds inpatient hospital services provided to incarcerated individuals who meet existing Medicaid eligibility criteria.

To the degree that a Medicaid expansion makes incarcerated individuals otherwise eligible for the program, the State could potentially lower its costs by claiming federal share for inpatient hospitalization services for eligible incarcerated individuals. Limits on current information regarding prisoner care costs make determining a precise savings estimate difficult.

Impact to Revenues

Louisiana Revised Statute 22:842 generally provides for the collection of a tax on the business of issuing health insurance based on 2.25 percent the insurer’s gross annual premiums. The statute provides any taxes collected under this provision against Medicaid Managed Care Organizations (MCO) to be deposited into DHH’s Medical Assistance Trust Fund (MATF). To the extent that any individuals who, as a result of a Medicaid expansion, enroll in the Bayou Health prepaid MCOs, the state would receive revenue based on the gross annual premiums paid to those plans. No tax is collected on the spending related to the Bayou Health shared savings health plans.

Some states, in their expansion analysis, have cited additional state revenue associated with increases sales and use taxes tied to the increased economic activity provided by the Medicaid expansion. As PAR noted in their analysis, this is a figure that should be viewed with some skepticism.

DHH believes it is an ancillary effect and should not play an influential role in the state's policy determinations regarding Medicaid expansion.

May 2010 Mercer Analysis

In the spring of 2010, DHH worked with its contract actuary, Mercer Government Health Services

Consulting, to complete a projection of the state fiscal impact based on key provisions of the Patient Protection and Affordable Care Act. These estimates were cumulative for the period 7/1/11 through 6/30/23 and categorized by degree of confidence or uncertainty. Below is a summary of these initial projections.

2010 Mercer Analysis

	<i>Enrollment Impact</i>	<i>State Costs (SGF) over 10 Years</i>	<i>Federal Costs Over 10 Years</i>	<i>Total</i>
High Degree of Certainty				
Newly Eligible Uninsured parents and childless adults	384,907	\$1.79 billion	\$25 billion	\$26.8 billion
Newly eligible adults and children who drop private coverage	233,331	\$1.2 billion	\$9.3 billion	\$10.5 billion
Parents currently eligible for Medicaid but not enrolled	27,606	\$701 million	\$1.4 billion	\$2.1 billion
Primary physician fee increases to 100 percent of Medicare		\$237 million	\$892 million	\$1.13 billion
Medicaid FMAP for Children 101-133 percent now in CHIP		\$291 million		
<i>The aggregate impact of above listed Medicaid expansion, ESI crowd out, and currently eligible but not enrolled parents 645,843 parents, children and childless adults⁵, with a cost impact of \$3.69 billion SGF (\$35.7 billion federal and \$39.4 billion total)⁶.</i>				
Uncertain				
Medicaid administration costs (includes 289 eligibility workers)		\$200 million	\$200 million	\$400 million
Specialty Physician fee increases to 110 percent of Medicare		\$226 million	\$1.23 billion	\$1.45 billion
Physician Utilization Increases		\$187 million	\$602 million	\$789 million
Hospital rate increases		\$1.5 billion	\$3.17 billion	\$4.73 billion
Hospital utilization increases		\$280 million	\$571 million	\$851 million
Community Mental Health Centers (see updates)		\$480 million	\$940 million	\$1.42 billion
Total	645,843	\$7.2 billion	\$43.3 billion	\$50.5 billion

Updates to 2010 Analysis

Since the 2010 analysis, there have been several developments that impact the original cost estimates. Recently, DHH has attempted to update its analysis to reflect new information and update its assumptions. These updates involve several specific areas, including:

- ▶ Participation Rates
- ▶ Cost of Coverage
- ▶ Administrative Costs
- ▶ Reimbursement and Utilization Rates
- ▶ Community Mental Health Centers
- ▶ CHIP FMAP
- ▶ DSH Savings
- ▶ Revenue Impact

DHH has provided both a low impact scenario and moderate to high impact scenario based on these updated assumptions.

Participation Rates

The original analysis included aggressive participation, or “take-up”, rates for individuals who would become eligible for Medicaid under an expansion. State assumptions regarding participation rates vary widely across the country, and there exists no clear standard by which to measure this phenomenon for the Medicaid expansion.

Since 2010, we have learned more about the behavior of this population through the implementation of the Greater New Orleans Community Health Connections (GNOCHC) waiver, which provides limited coverage for individuals beneath 200 percent of FPL in the Greater New Orleans area. Based on the experience in GNOCHC, as well as other expanded programs like the Family Planning Waiver, Disability Medicaid, certain behavioral health populations, and existing crowd-out populations, those participation rates have been updated to provide for several benchmarks in the Department’s latest analysis.

Participation Rate Assumptions

Population	2010 Assumption	Low Impact Scenario	Moderate to High Impact Scenario
Newly Eligible	(All newly eligible) 80 percent in 2014 95 percent by 2017	(Other than below groups) 30 percent in 2014 95 percent by 2019	(Other than below groups) 75 percent in 2014 95 percent by 2019
<i>GNOCHC</i>	--	100 percent in 2014	100 percent in 2014
<i>Disability Medicaid</i>	--	100 percent in 2014	100 percent in 2014
<i>Family Planning</i>	--	100 percent in 2014	100 percent in 2014
<i>OBH Non-Medicaid</i>	--	100 percent in 2014	100 percent in 2014
Crowd Out	80 percent in 2014 and after	25 percent in 2014 40 percent by 2019	50 percent in 2014 75 percent by 2019
Woodwork	10 percent in 2011 30 percent in 2012 50 percent in 2013 85 percent in 2015 90 percent in 2016 95 percent by 2017	25 percent by 2019	50 percent by 2019

Cost of Coverage

For the newly eligible population, the cost of coverage diminishes to the state over time if fewer individuals enroll based on revised participation rates. Furthermore, Bayou Health provides for savings over initial projects as the program has lowered costs and provided DHH with a more stable and accurate assessment of the Medical costs the Department could expect to incur. Both updated scenarios account for Bayou Health cost containment.

Administrative Costs

Since these costs are being incurred regardless, DHH has eliminated consideration of costs associated with the procurement and built out of a new Medicaid MMIS system and a new eligibility system. Since the original analysis, Louisiana has opted for the Federally-Facilitated Exchange option, and CMS has issued guidance that the FFE will have the ability (if state chooses) to make Medicaid eligibility determinations. This will lower the overall staffing and outreach costs associated with a Medicaid expansion.

Reimbursement and Utilization Rates

To offset uncompensated costs, some hospitals receive Disproportionate Share (DSH) payments. Medicaid DSH payments pay for either the difference between Medicaid rates and actual cost ("Medicaid shortfall") and/or the actual cost of care to the uninsured. With the expansion of Medicaid to adults below 133 percent FPL, the health care system as a whole will depend more on the Medicaid program as a payer source at the same time as DSH allocations, including those that pay for the Medicaid shortfall, to states are reduced. The result may be an increase in uncompensated cost for hospital services provided to Medicaid enrollees. DHH's original impact analysis assumed that Medicaid rates for inpatient and outpatient hospital services would have to increase to 90 percent of cost to prevent or moderate increases in hospital uncompensated cost from Medicaid shortfall.

The low impact scenario assumes DHH will not increase rates. The moderate to high impact scenario includes an assumption that physician rates would

increase to 100 percent of Medicare and Hospital Payments would increase to 90 percent of cost.

The original estimate for costs associated with utilization was made before Bayou Health was implemented to better manage the coordination and delivery of services, and has thus been trended downward in both scenarios.

Community Mental Health Centers

PPACA requires Community Mental Health Centers to increase services to non-Medicare eligible individuals to at least 40 percent. At the time of the 2010 Mercer analysis, 50 of Louisiana's 64 Medicare Certified Community Mental Health Centers (CMHC) were enrolled in Medicaid. In SFY 2008-09, enrolled CMHCs served 5,720 dually eligible Medicare/Medicaid recipients whose Medicaid claims represented less than 10 percent of CMHC business. Medicaid pays zero for CMHC claims for services provided to patients who are dually eligible for Medicare and Medicaid. PPACA requires CMHCs to increase their non-Medicare services until each CMHC provides at least 40 percent of its services to individuals who are not eligible for benefits under Medicare by April 2011.

The Louisiana Association of Behavioral Health petitioned DHH for relief in the form of Medicaid coverage of CHMC services. If granted, Medicaid would have to develop a payment methodology that supports CMS's accounting of services provided and contract out or increase State employment to administer the program expansion, including but not limited to strict program criteria and robust oversight and monitoring to protect against fraud and abuse.⁷ Since the time of the 2010 analysis, DHH has determined that this is not the responsibility of the state and has removed these cost estimates from its consideration in both updated scenarios.

CHIP FMAP

Louisiana originally projected that, because the Medicaid FMAP rate is lower than the CHIP FMAP rate, the federal government will pay a smaller share of the total cost of Medicaid services provided

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to children enrolled today between 101 and 133 percent FPL and more SGF will be needed to maintain coverage of this population. However, since that time, CMS has issued guidance that clarifies that enhanced CHIP FMAP rate will still apply to this population.

DSH Savings

Original estimates by Mercer did not factor in savings in Disproportionate Share Hospital (DSH) funding as the number of uninsured declined. There are forces both inclusive and exclusive of the Medicaid expansion that will impact Louisiana's future DSH need. Regardless of the decision to expand, it can be reasonably anticipated that DSH needs will decrease because of three externalities:

- ▶ A reduction in the number uninsured due to the availability of subsidized coverage in the Exchange
- ▶ An improving economy that increases the number of individuals with employer sponsored coverage or the ability to purchase coverage, and

- ▶ Efficiencies in the state public hospital system through an ongoing system redesign that reduce the need for DSH funding.

Based on these expectations, DHH developed a new anticipated base DSH need before calculating anticipated savings in DSH related to any future Medicaid expansion. From there, DHH applied an increasing DSH reduction over time. The percentage reduction is based on our expectation that it will take some time for individuals to enroll in coverage and for the systems that cares for the uninsured to adapt to the new financing schema. Furthermore, DHH does not believe the need for DSH will ever diminish entirely. As noted earlier in this report, CBO projects that there will still be 29 million uninsured individuals in 2019.

Based on these considerations, DHH estimates a total reduction in DSH need over 10 years of \$419.5 million in state general fund.

DSH Savings Calculation

State Fiscal Year	Base SGF DSH Amount	Percent Reduction	SGF Reduction
2014 (half year)	\$225 million	5%	\$11.25 million
2015	\$175 million	15%	\$26.25 million
2016	\$150 million	20%	\$30 million
2017	\$140 million	25%	\$35 million
2018	\$130 million	30%	\$39 million
2019	\$120 million	40%	\$48 million
2020	\$115 million	50%	\$57.5 million
2021	\$115 million	50%	\$57.5 million
2022	\$115 million	50%	\$57.5 million
2023	\$115 million	50%	\$57.5 million
Total			\$419.5 million

Revenue Impact

Early analyses assumed that all newly enrolled lives would be enrolled into one of Bayou Health's prepaid health plans, subjecting the premium revenue associated with those lives to the health insurance premium tax. However, as of the most recent Bayou Health enrollment report (January 2013), 49 percent of Bayou Health enrollees are enrolled in one of the two "shared savings" health plans, whose revenues are not subject to the premium tax. DHH has no plans at this time to change its policy regarding assignment and choice

of health plans. Therefore, the updated scenarios reduced the premium tax revenue by half.

Furthermore, health plans have the ability to exercise certain offsets that would eliminate up to approximately 80 percent of the tax. Therefore, the below summary provides a range of tax revenue based on the potential for these offsets.

The below chart summarizes the major changes that were made in a recent internal update to the 2010 Mercer analysis.

Medicaid Expansion Impact Projections

Cost/ impact Over Ten Years (costs are SGF)	2010 Assumption	Low Impact Scenario	Moderate to High Impact
Participation rate (varies by population)	----- See above chart -----		
Total enrolled	645,843	577,329	653,305
Cost of coverage	\$3.7 billion	\$1.07 billion	\$1.32 billion
Administrative Costs	\$200.1 million	\$72.02 million	\$73.5 million
Reimbursement rate and utilization adjustments	\$2.48 billion	Assuming None	\$1.67 billion
Community Mental Health Center Gap Fix	\$488.5 million	N/A	N/A
CHIP FMAP	\$291.5 million	N/A	N/A
ACA PCP Increase After 2014		\$31.6 million	\$37.4 million
Existing groups considered newly eligible		(\$908.04 million)	(\$908.04 million)
Revenue Impact		(\$42.7 - \$213.7 million)	(\$49.2 - \$246.1 million)
DSH Savings		(\$419.5 million)	(\$419.5 million)
Total	\$7.17 billion	(\$196.5 – \$367.5 million)	\$1.52 - \$1.71 billion

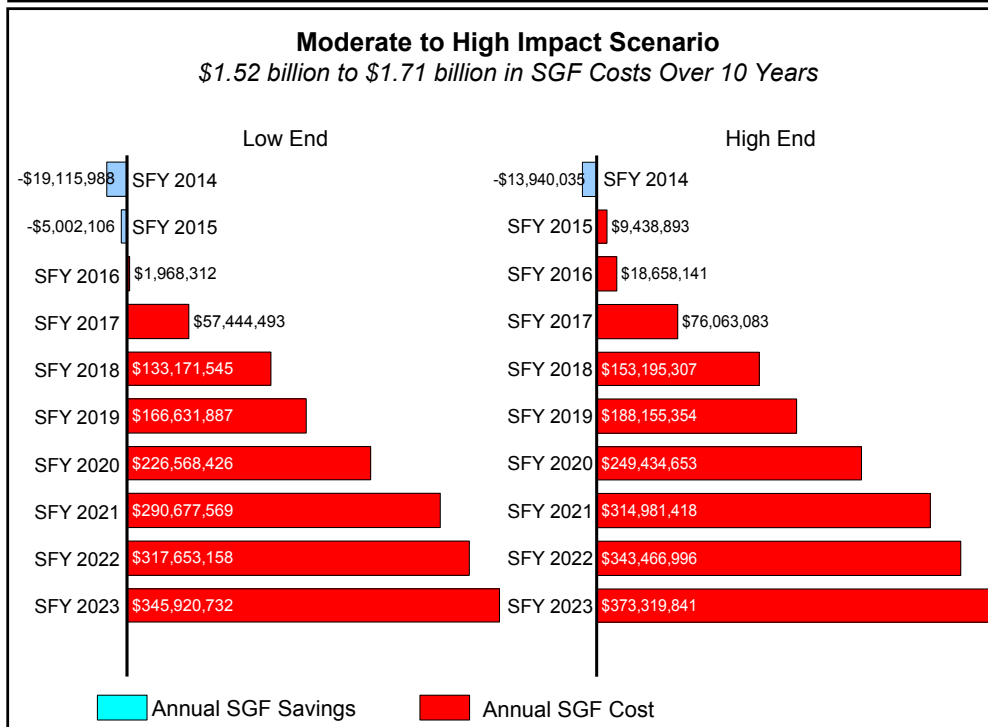
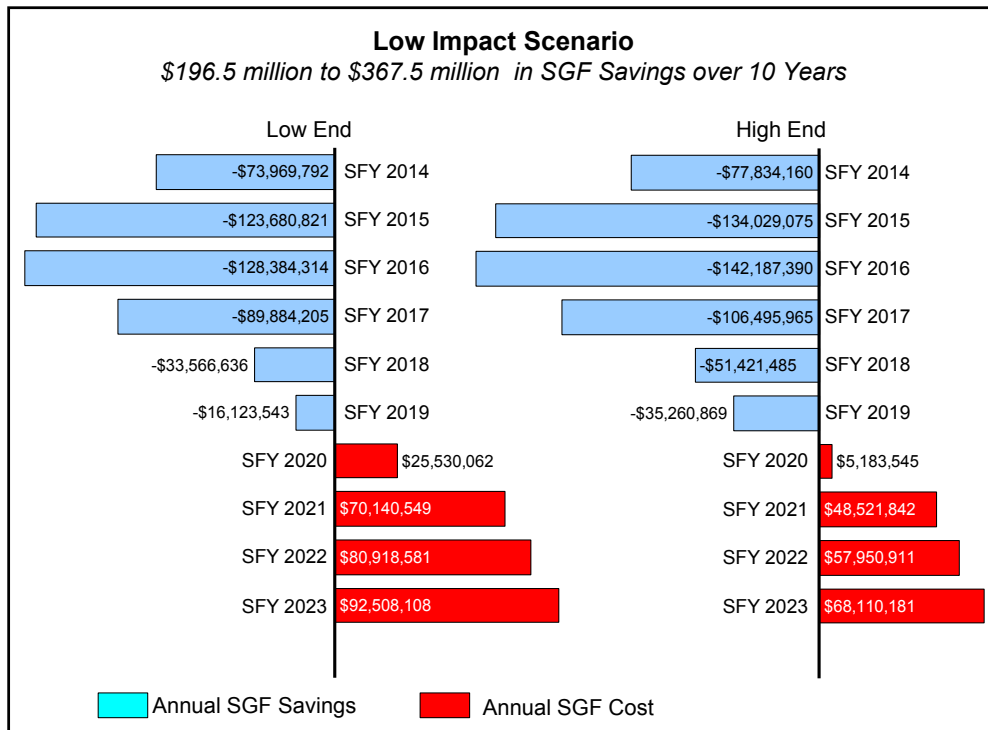
Understanding the Impact of a Medicaid Expansion in Louisiana

This represents a broad range of potential liability for the state should it ever choose to pursue a Medicaid expansion as envisioned by PPACA.

Costs over Time

In addition to understanding the aggregate impact over time, it is important for policymakers to

understand that the costs associated with expansion vary as time progresses. Federal support for newly eligible individuals is front loaded, and states must begin providing some financial support after calendar year three. The below charts provide a visual representation of the annual costs (and savings) associated with both updated scenarios presented.



Reforms Needed

Louisiana, along with other states, has laid out clear principles of reform to strengthen the Medicaid program. Like other states, we believe that Medicaid must be reformed before it can effectively be used as a vehicle for coverage expansion. Below are the tenets of reform that should guide these efforts:

1. First, the process to determine Medicaid eligibility should be simple, accurate and fair.

There are far too many complicated categories of Medicaid eligibility. The process should be easier for consumers to navigate and states to administer. For any expansion, the rules for how to identify who is newly eligible for Medicaid versus those who would have traditionally been eligible must be administratively simple on the front end and not impose an overly difficult audit procedure at the end of the year. We cannot afford to base billions of dollars in payments to states on untested methodologies that pose significant risk to state budgets.

We also believe that the adoption and use of Modified Adjusted Gross Income (MAGI) will have a disruptive effect on the Medicaid eligibility system and create new inequities among households. States should not have to bear the additional costs of running multiple eligibility systems.

The Exchanges should be held to the same program integrity rules and regulations as state Medicaid programs. States must maintain the authority for setting eligibility rules to protect the program's integrity.

2. States should be allowed to design their program to promote value and individual ownership in health care decisions.

This includes using consumer-directed products, flexible benefit design and reasonable and enforceable cost-sharing requirements. States must be freed decades old rules that are no longer relevant to 21st century health care. Just like those of us with employer-sponsored coverage or Medicare, Medicaid recipients should not have free access to the emergency room for routine care. When individuals have

no bested interest, they are less likely to consume care responsibly.

3. States should be able to make use of their private health insurance market through their Medicaid eligibility levels, program design and ability to offer premium assistance.

States should have the ability to set eligibility requirements for both their current enrollees and expansion population. For example, states should be allowed the flexibility to set their Medicaid eligibility limits at less than 138 percent Federal Poverty Level and still receive the enhanced FMAP.

Additionally, the law currently prevents states from moving children enrolled in their state's CHIP program to their parent's insurance coverage purchased in an Exchange until 2019. With reasonable plans from a state to provide for continued coverage for currently enrolled children, HHS should waive CHIP maintenance of effort (MOE) requirements not set to expire until 2019. This would allow children to be enrolled in private health insurance plans with their parents or caretakers, rather than shifting healthy risk from the private health insurance market and separating families into different public and private health coverage programs. There is value in keeping families together and having them engage with only one health plan, which will ease their use and promote utilization of routine preventive services.

4. HHS should allow a state to grant "premium assistance" for individuals to buy-into the exchange market place at any income level, rather than be forced into the Medicaid system simply because they are low-income.

HHS should also return full authority to states for setting reimbursement and payment policies, including flexibility to promote value-based insurance design. States should also have full authority for contracting and oversight of managed care, including the ability to place any Medicaid recipient into a managed care setting.

5. Finally, HHS should streamline Medicaid financing and improve the waiver process to give states more flexibility, coupled with

greater accountability tied to improvements in health outcomes.

The process by which states negotiate for flexibility, called “waivers”, is broken. Federal officials should have greater accountability for timely review of waiver applications. In particular, waivers already approved in other states should be fast-tracked for approval.

HHS should allow states to opt-in to a more flexible long-term funding arrangement, allowing them to design programs that best meet their people’s needs, rather than one-size-fits all programs that require the same package of services for every individual. At the same time, federal and state officials could agree to greater accountability for improvements in health outcomes, not just processes.

Conclusion

There continue to be many unknowns regarding the direct and ancillary effects of expanding Medicaid

in Louisiana. Our ability to calculate a precise budgetary and programmatic impact is limited. Broad assumptions must be made, with very little direct precedent to guide decision makers. The result is a wide range of potential impact that Louisiana exposes itself to by choosing the expand Medicaid. Policymakers must understand both the possibility of potential savings, as well as the risk of future costs, when contemplating the effects of expanding Medicaid in Louisiana.

We’ve seen encouraging signs that federal officials are beginning to listen to states who are seeking important flexibilities in their program. But it is important for HHS to engage with every state that has expressed an interest in pursuing common sense reforms to Medicaid, regardless of the their decision to expand. Louisiana is actively watching the progress of discussions between federal officials and other states.

- 1 Louisiana’s Uninsured Population: A Report from the 2011 Louisiana Health Insurance Survey; January 2012; LSU Division of Economic Development -LSU Public Policy Research Lab. Available at: http://new.dhh.louisiana.gov/assets/medicaid/LHIS/2011LHIS/LHIS_Layout_FINAL_000.pdf
- 2 Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau’s March 2011 and 2012 Current Population Survey (CPS: Annual Social and Economic Supplements).
- 3 CBO Analysis, February 2013; http://cbo.gov/sites/default/files/cbofiles/attachments/43900_ACAInsuranceCoverageEffects.pdf
- 4 CMS Guidance to States on Mental Health Parity Requirements, January 16, 2013; <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf>
- 5 Estimate by Mercer Government Human Services Consulting. See Mercer memo “Medicaid Expansion Estimates (January 1, 2014 to June 30, 2020)” dated 2/25/10.
- 6 Estimate by Mercer. See Mercer memo “Healthcare Reform Crowd-Out Analysis” dated 4/18/10
- 7 A 2007 Office of the Inspector General report on 2003 Medicare payments for mental health services indicated 47 percent of services did not meet requirements due to miscoding, lack of documentation, no medical necessity and fraud, resulting in \$718 million in improper payments.

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For additional information, please visit
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